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Notice of Independent Review Decision

Date notice sent to all parties: 07/18/12
IRO CASE #:
DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Left knee arthroscopy

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
Board Certified in Orthopedic Surgery

REVIEW OUTCOME:
Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

X Upheld	(Agree)
☐ Overturned	(Disagree)
☐ Partially Overturned	(Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

Left knee arthroscopy - Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW:
Operative reports dated 11/13/09 and 03/25/10
Emergency room discharge instructions dated 02/04/10
Reports from M.D. dated 02/15/00, 03/01/10, 04/05/10, 05/10/10, 09/20/10, 05/11/11, 02/22/12, 04/04/12, 05/16/12, 06/15/12, and 06/25/12
X-ray report dated 02/17/10
Left knee MRIs dated 02/24/10 and 05/31/12 and interpreted by, M.D.
MRI review from Dr. dated 03/01/10
History and Physical dated 03/25/10 with Dr.
A letter from Dr. dated 04/27/10
Preauthorization fax requests dated 06/18/12 and 06/26/12 from Dr.
Physician Advisor Reports from dated 06/20/12 and 06/29/12
Utilization Review determinations from dated 06/21/12 and 06/29/12
The Official Disability Guidelines (ODG) used were not provided by the carrier or the URA

PATIENT CLINICAL HISTORY [SUMMARY]:
M.D. performed left knee arthroscopy with a partial medial meniscectomy, chondroplasty of affected areas, and debridement of the ganglion cyst on 11/13/09. Dr. examined the patient on 02/15/10. He still had limited motion and an MRI was recommended, which was performed on 02/24/10. It revealed developing bone infarcts of the tibial plateau and distal femoris. There was extensive interstitial mucoid degeneration of the ACL with adjacent subchondal cyst in the roof of the intracondylar notch. There was a very subtle occult "fracture" of the posterolateral tibial plateau with associated bone contusion. A horizontal re-tear of the residual midbody medial mensicus was noted. Dr. reviewed the MRI on 03/01/10 and recommended additional arthroscopic surgery, which was performed on 03/25/10. He performed left knee arthroscopy, partial medial meniscectomy, light abrasion chondroplasty in the areas of the full thickness loss in a patch of Grade III chondromalacia involving the medial femoral condyle, ACL repair, and use of thermal shrinkage for the ACL repair. On 04/05/10, Dr. noted the patient had quadriceps atrophy and recommended therapy. On 09/20/10, the patient returned to Dr. She had mild to moderate medial joint line pain six months status post surgery. A Cortisone injection was discussed, which performed with ultrasound guidance. Dr. reexamined the patient on 05/11/11. She had six to seven months improvement following the injection. Another Cortisone injection was performed at that time. On 02/22/12, the patient informed Dr. the last Cortisone injection did not help much. McMurray's was negative and there was no evidence of a re-tear. He felt the patient was having medial pain from either a lack of meniscus versus intermittent gout flares, but it did not clinically appear to be a new meniscal tear. Another steroid injection was performed. The patient's pain complaints were essentially unchanged on 05/16/12 and Dr. performed another Cortisone injection. Another left knee MRI was performed on 05/31/12 and revealed several large bone infarcts about the knee and prominent subchondral cyst formation at the roof of the trochlear notch and the mass was connected with the PCL. There was diffuse interstitial degeneration of the PCL and the ACL was poorly visualized. The residual mid body of the posterior horn of the meniscus appeared irregular, which was concerning for additional tears. Dr. reviewed the MRI on 06/15/12. Additional left knee arthroscopy was recommended, which was non-authorized by on 06/21/12. On 06/25/12, the patient presented to Dr. to discuss his surgical options. On 06/26/12, Dr. requested a left knee arthroscopy. Travelers provided another notice of adverse determination of the left knee arthroscopy on 06/29/12.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
The patient is a male who has undergone two separate arthroscopic procedures, the first on xx/xx/xx by Dr. and the second on xx/xx/xx by Dr.. The patient is a male. The evidence based ODG does not recommend second look arthroscopy except in cases of complications from OATS or ACI procedures to assess how the repair is healing. The ODG indications for surgery include conservative care to consist of medications or physical therapy, substantial subjective clinical findings of pain and functional limitations that continue despite conservative care, and the

imaging is inconclusive. It is not recommended for osteoarthritis in the absence of meniscal findings (Kukley 2008). Arthroscopic surgery for knee osteoarthritis offers no additional benefit to optimize physical therapy and medical therapy according to the results of a single center randomized clinical trial reported in the *New England Journal of Medicine*. The study combined with other evidence indicates that osteoarthritis of the knee (in the absence of history and physical findings suggestive of meniscal or other findings) is not an indication for arthroscopic surgery and indeed has been associated with inferior outcomes after arthroscopic knee surgery. AHRQ Effectiveness Research concluded that arthroscopic lavage for osteoarthritis with or without debridement does not improve pain and function for people with osteoarthritis of the knee (AHRQ 2011). This patient has significantly advanced osteoarthritis as noted above. He has had limited benefit from two prior knee arthroscopies. He clearly does not meet the evidence based criteria for arthroscopy according to the ODG. Therefore, the requested left knee arthroscopy is not medically necessary, reasonable, related, or supported by the evidence based ODG and the previous adverse determinations should be upheld at this time.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ☐ **ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- ☐ **AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**
- ☐ **DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- ☐ **EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**
- ☐ **INTERQUAL CRITERIA**
- **X MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- **X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- ☐ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- ☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- ☐ **TEXAS TACADA GUIDELINES**
- ☐ **TMF SCREENING CRITERIA MANUAL**
- ☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- **X OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**
  New England Journal of Medicine